Creating Positive Turbulence

A Tobacco Quit Plan for California

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California Department of Public Health
California Tobacco Control Program

Creating Positive Turbulence
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Held in
San Diego, California
May 7-8, 2009

Edmund G. Brown Jr., Governor
State of California

Kimberly Belshé, Secretary
California Health and Human Services Agency

California Department of PublicHealth

California Tobacco Control Program

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FOREWORD

Since its inception 20 years ago, the California Department of Public Health (CDPH), California Tobacco Control Program (CTCP) has been charged with decreasing tobacco-related disease and death by protecting Californians from secondhand smoke (SHS) and reducing tobacco use across the state. The landmark 1988 California Tobacco Tax and Health Promotion Act (Proposition 99) made California the first state to implement a comprehensive tobacco control program and begin work toward its life enhancing goals. Significant progress has been made as per capita tobacco consumption has been cut in half and health outcomes have improved. Even lung and bronchial cancers have declined much faster in California than in the rest of the United States (Pierce et al, 2010).

The primary intervention goal of CTCP is to change the social norms surrounding tobacco use by creating a social milieu and legal climate in which tobacco becomes less desirable and accessible and tobacco use becomes less socially acceptable, thereby discouraging future tobacco users from starting and encouraging current users to quit (California Department of Public Health, 2009). Employing the social norm change model, CTCP focuses its tobacco control activities in four priority areas:

1. Countering pro-tobacco influences in the community: de-glamorizing tobacco use through an anti-tobacco media campaign, curbing promotion, restricting tobacco industry sponsorship of sports and community events, and other counter-marketing activities.
2. Reducing exposure to SHS: using policy and advocacy to restrict smoking in public and private places. Emerging areas of focus include policies associated with Indian casinos, multi-unit housing, and outdoor venues.
3. Reducing the availability of tobacco: requiring licensure of tobacco retailers, enforcing laws that prohibit tobacco sales to minors, eliminating free tobacco product sampling, and inducing pharmacies to stop selling tobacco.
4. Promoting services that help smokers quit: marketing a statewide tobacco quitline and encouraging health care providers and other professionals to refer tobacco users to it.

Building on the fourth of these priority areas, CTCP hosted a summit meeting on May 7-8, 2009, entitled "Creating Positive Turbulence: A Tobacco Quit Plan for California." The summit convened a diverse group of local, state, national, and international leaders to assist CTCP in developing a new Quit Plan for California. Participants included health care and public health experts, policy makers, marketing experts, and leaders in tobacco cessation service delivery.

These leaders were tasked with identifying program and policy strategies that can be implemented in California to promote quit attempts and increase tobacco cessation on the population level. The aim of the summit was to create an evidence-based and theoretically coherent plan to guide CTCP's efforts to increase tobacco cessation in California, given currently available resources. This report outlines the elements of that plan.

ACKNOWLEDGMENTS

The California Tobacco Control Program (CTCP) would like to acknowledge the members of the Planning Committee for their vision, expertise, and hard work to ensure the success of the cessation summit: Christopher Anderson, Linda Aragon, Majel Arnold, Bridget Gleason, Kirsten Hansen, Byron Kennedy, Beth Lillard, Barbara Lowell, Connie Revell, Beth Thompson, and Elisa Tong.

CTCP also expresses its gratitude to all the summit participants and presenters, many of whom traveled great distances to share their expertise and participate in discussions about cessation strategies. Their insights provided the substance of this report. The presenters, Linda Aragon, Robin Corelli, Jonathan Fielding, Ali Goldstein, Ed Mendoza, Chad Morris, John Pierce, Connie Revell, April Roeseler, Patrick Romano, Steven Schroeder, Colleen Stevens, Melanie Wakefield, and Shu-Hong Zhu, and the facilitator, Jolie Bain Pillsbury, deserve special thanks for their outstanding contributions to the success of the summit.

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BACKGROUND AND PURPOSE OF THE SUMMIT

The Charge: Cessation 2.0

Two related concepts served as guideposts for "Creating Positive Turbulence: A Tobacco Quit Plan for California." Created by Stanley Gryskiewicz, the term "positive turbulence" describes a climate in which leaders promote beneficial changes in their organizations or in society by fostering creativity, recombination, and reinvention and by stimulating individual contributions toward a shared goal (Gryskiewicz, 1999). Web 2.0 refers to the second generation of Web development that has revolutionized the Internet, leading to the creation of Web based communities, social networking sites, video-sharing sites, wikis, blogs, and more.

The California Department of Public Health (CDPH) asked summit participants to apply these concepts to tobacco cessation and make similarly transformative recommendations representing "Cessation 2.0." We asked them to think creatively about what could be done in California, beyond simply doing a better job implementing current best practices or adopting good ideas from other states. We asked them to take what is known about cessation, the political and economic environment, the health care delivery system, partnerships, and marketing and to recombine this knowledge in new ways, or with strategies and technologies from other fields to raise California to a new level with respect to cessation. We challenged participants to develop strategies that would be relevant in the new economy and to look for ways to develop new connections focusing more on cooperation than on coercion to create sustained change. Just as the power of Web 2.0 derives from the decentralized, voluntary participation of thousands of individuals, the power of Cessation 2.0 should derive from its potential to engage active, new partners.

The Quit Plan for California thus adopts strategies designed to have a ripple effect throughout the state, resulting in a sustained, renewable approach to cessation that emphasizes and demonstrates the value of "opting in" by tobacco users and those who interact with them.

The Quit Plan for California thus adopts strategies designed to have a ripple effect throughout the state, resulting in a sustained, renewable approach to cessation that emphasizes and demonstrates the value of "opting in" by tobacco users and those who interact with them, including friends and family as well as professionals in business, health care, health insurance, social services, and mental health and substance abuse treatment.

Considerations Guiding the Discussion

Current funding for CTCP is approximately $55 million annually, with budget reductions anticipated. Funding available to the CTCP Media Campaign continues to decline while the cost of advertisement (ad) placement keeps rising. Local health departments also have shrinking budgets for tobacco control. For these reasons, the Quit Plan for California favors low- or no-cost strategies using partnerships and outside resources.

Despite the second-lowest rate of tobacco use in the nation, California still has nearly four million smokers, equivalent to the population of Oregon

(Al-Delaimy et al., 2008). CDPH charged summit participants with determining how to encourage and support these four million smokers to quit, in ways that are:

- fiscally responsible and realistic with respect to the state of the economy;
- population-based;
- marketable in a cost-effective manner;
- likely to be embraced by health care providers and insurers; and
- forward thinking and boundary-testing.

Four topics were not discussed at the summit:

1. Increasing the state's tobacco tax. CTCP requires a Quit Plan that is viable without additional resources.
2. Mandating health insurance coverage of cessation treatment. This issue was included in recent or current comprehensive health insurance proposals under consideration at the state and federal levels.[1]
3. Expanding face-to-face cessation services or alternative treatments. These are costly to provide and, in the case of alternative treatments, lack clear evidence of effectiveness.
4. Adopting harm reduction strategies. CTCP does not support harm reduction as a cessation strategy as there is a lack of scientific evidence demonstrating its effectiveness and effect at both the individual and population levels.

Despite the second-lowest rate of tobacco use in the nation, California still has nearly four million smokers.

Increasingly, tobacco use is associated with low socioeconomic status, mental illness, and substance abuse.

Other Important Considerations

Efforts to increase tobacco cessation should be viewed in the context of the larger discussion of health care reform. Several of the themes from that discussion are favorable to tobacco cessation. These include a focus on prevention and wellness rather than on simply treating disease, the importance of cost-efficiency in treatment selection, the benefits of coordinated chronic disease management and of integrated patient care systems such as electronic medical records, and the need to address disparities in access to treatment to improve overall health outcomes. From the broader discussion of health care reform, new systems and practices will emerge, presenting a golden opportunity to incorporate Cessation 2.0 strategies into health care in a systematic way.

Although tobacco use is receding in California, the prevalence is still high in certain groups. American Indians/Alaska Natives, African Americans, Asian men, Caucasian men, lesbian/gay/bisexual/transgender individuals, enlisted military personnel, and rural residents have higher rates of tobacco use than the general population (Al-Delaimy et al., 2008). Increasingly, tobacco use is associated with low socioeconomic status (SES), mental illness, and substance abuse (Centers for Disease Control and Prevention, 2008; Lasser et al., 2000). To continue lowering the overall prevalence of tobacco use in the state, California must increase cessation efforts within these subgroups.

[1]The Patient Protection and Affordable Care Act (Pub.L. 111-148, 124 Stat. 119, to be codified as amended at scattered sections of 42 U.S.C.) was signed into law by President Barack Obama on March 23, 2010. Effective September 23, 2010, insurers are prohibited from charging co-payments or deductibles for preventive care and medical screenings on all *new* insurance plans and by 2018 all existing health insurance plans must cover checkups and other preventive care without co-pays. Medicaid would start covering stop-smoking services for pregnant women starting in October 2010.

California is fortunate to have many strong, local organizations that are engaged in tobacco control and can act as proponents and messengers of change. But resources are often scarce for these organizations, so it is important to give careful consideration to how they can incorporate low- or no-cost Cessation 2.0 strategies into their current activities, in particular by recruiting additional active partners.

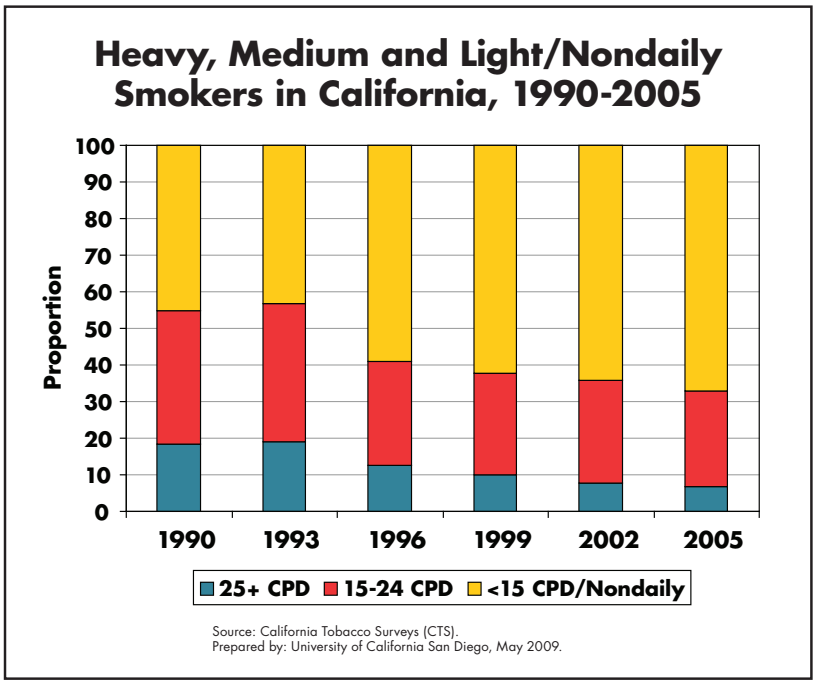
California is fortunate to have many strong, local organizations that are engaged in tobacco control who can act as proponents and messengers of change.

On a population level, the strategies that are most effective in reducing the prevalence of tobacco use are those that increase the frequency of quit attempts (Zhu, 2006). Current resources are insufficient to provide cessation assistance to all smokers for every quit attempt. Not all smokers want assistance, though the majority of them do want to quit. "Self quitting," while it has a low efficacy rate, is still the most common route to successful quitting (Chapman and Mackenzie, 2010).

THE DEMOGRAPHICS OF TOBACCO USE IN CALIFORNIA

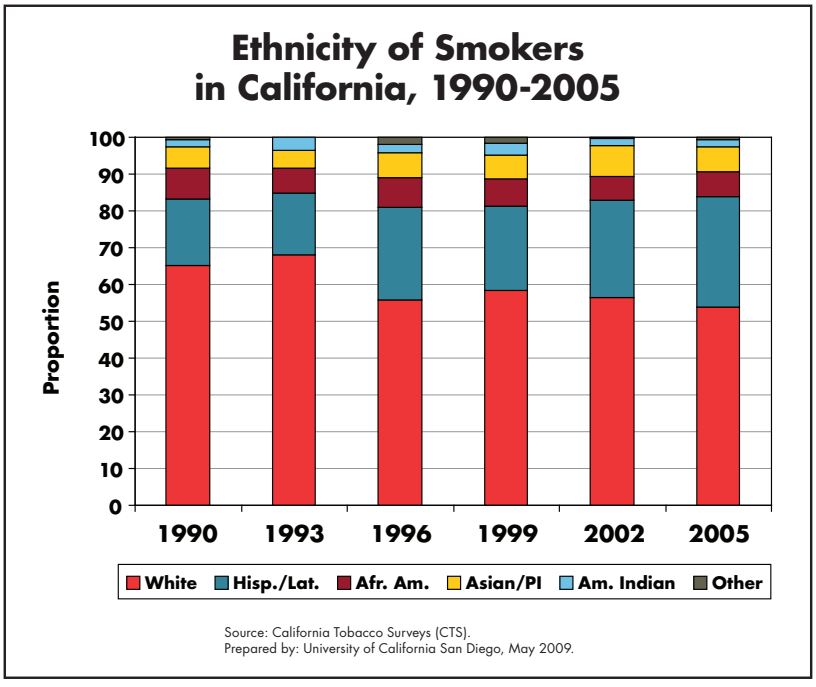
Prevalence and Consumption

California has made significant progress in reducing tobacco use. The prevalence of smoking among adults fell from 26.7 percent in 1985 to 13.1 percent in 2009, and average consumption among those who do smoke fell from 14 cigarettes per day (CPD) in 1992 to 10 CPD in 2007. In 1990, light users (<15 CPD) accounted for fewer than half of smokers, but by 2005 they represented over two-thirds.



The reduction in tobacco prevalence and consumption has been accompanied by an ethnic shift. In 1990, nearly 65 percent of smokers were white, whereas in 2005 only 54 percent were white. Latinos, on the other hand, increased their share of the smokers from 18 to 30 percent over the same period, mainly due to faster population growth.

The fact that Californians who use tobacco today are more likely to be light or non-daily consumers has tremendous implications for cessation messaging and



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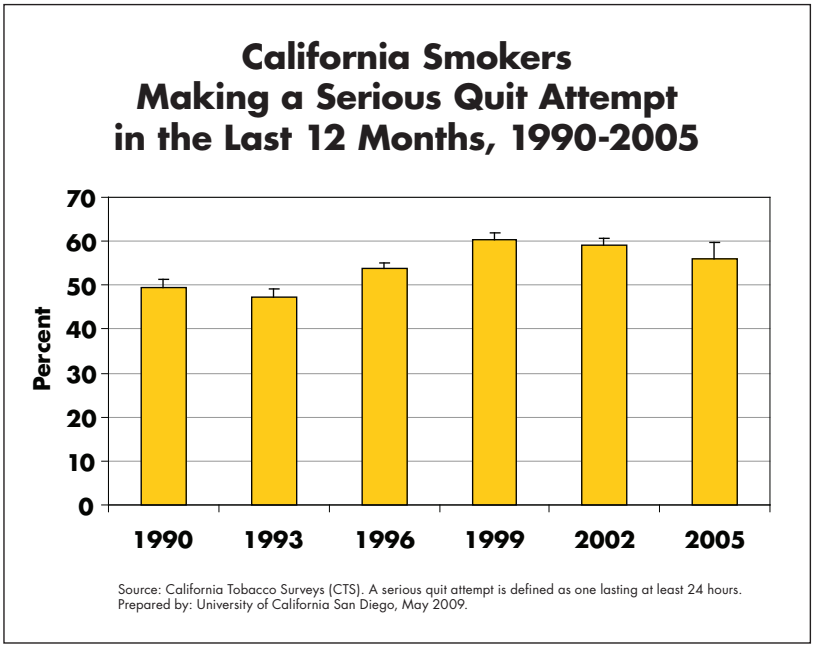
treatment. For example, medications are not recommended for this group, and they may not even consider themselves to be "real" smokers if they smoke on a non-daily basis (Tong et al., 2006). Also, certain demographic groups, most notably Latinos, are more likely than others to be light or non-daily smokers (Zhu et al., 2007). Efforts to promote cessation must address these important shifts in the demographics of tobacco use in California.

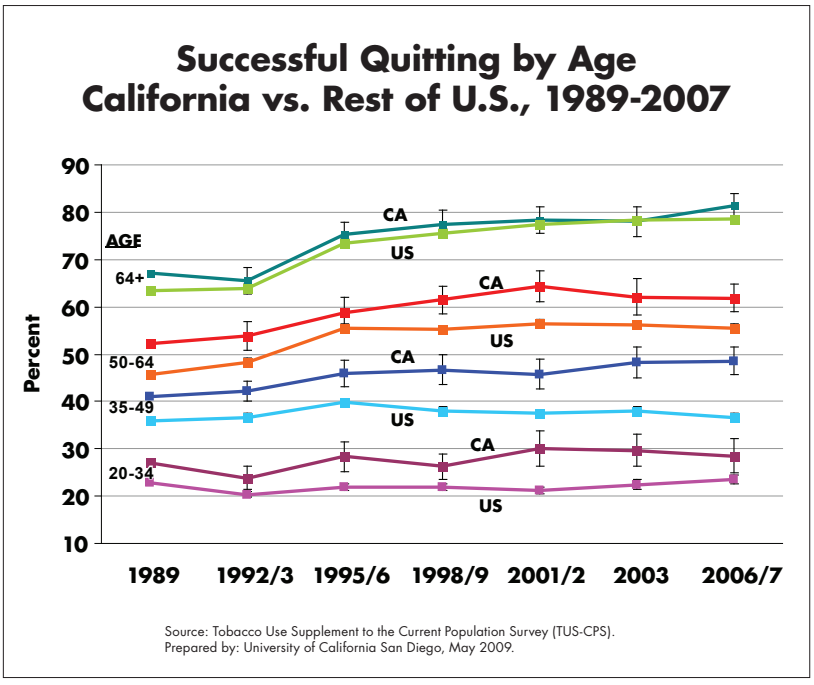
Despite the trend toward lower smoking prevalence and increased low-rate smoking, the following groups' prevalence and/or consumption rates are much higher than the average:

- African Americans;
- American Indians/Alaska Natives;
- Asian men;
- Caucasian men;
- Enlisted military personnel;
- Lesbian/gay/bisexual/transgender individuals;
- Rural residents;
- Individuals of low SES; and
- People with mental health and substance use disorders.

Quit attempts are vitally important in population-based cessation, because most tobacco users must try repeatedly to quit before they succeed.

CTCP has had the greatest effect on social norms in communities consisting largely of higher SES, white, heterosexual civilians with relatively little mental illness or substance abuse, and this is where the rates of tobacco use are now lowest. In some communities, cultural norms still support and even encourage smoking. Tobacco users are now much likelier to belong to one or more of the groups listed above, so the associated cultural differences must be addressed in efforts to increase cessation.





Quitting Activity

In the first decade of the CTCP, there was a significant increase in the percentage of smokers thinking of quitting and actually making a serious quit attempt (defined as quitting for at least 24 hours). In 1990, about 50 percent of smokers had made a quit attempt in the past year. By 1999, it had increased to about 60 percent. Unfortunately, over the past decade the percentage has stopped rising and may even be trending downward (though the apparent decline in the most recent survey is not statistically significant). Quit attempts are vitally important in population-based cessation, because most tobacco users must try repeatedly to quit before they succeed. Every percentage point increase means an additional 40,000 smokers trying to quit each year. Fortunately, the percentage of smokers who say they want to quit has remained high, approximately 70 percent, indicating a basic receptivity to cessation messaging.

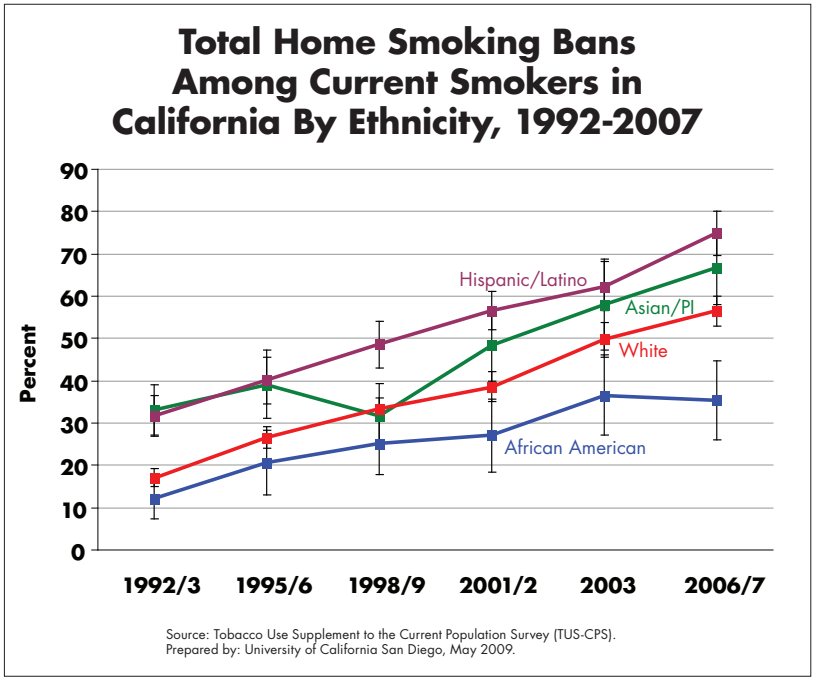
> The percentage of Californians that have implemented a nonsmoking policy in the home has tripled since 1992-93.

An analysis of those who have quit successfully shows several interesting trends. The majority of both male and female ever-smokers in California had successfully quit by 2007. The majority of ever-smokers aged 50 years or older, both in California and elsewhere in the United States, had likewise successfully quit. Consistent with the idea that most smokers must make multiple attempts before they quit for good, older smokers are more likely to have quit successfully. In all age groups, California smokers have done significantly better than their counterparts elsewhere in the United States, but the difference is greatest in the 35-49 year old group.

Both in California and elsewhere in the United States, college-educated white smokers are the only racial and educational subgroup to have achieved quitting success by over half of its members, though all such subgroups in California have been trending upward in the percentage of ever-smokers who have quit. A special focus on encouraging quit attempts among younger, non-white, less educated smokers in California is warranted.

Environmental Factors that Support Quitting

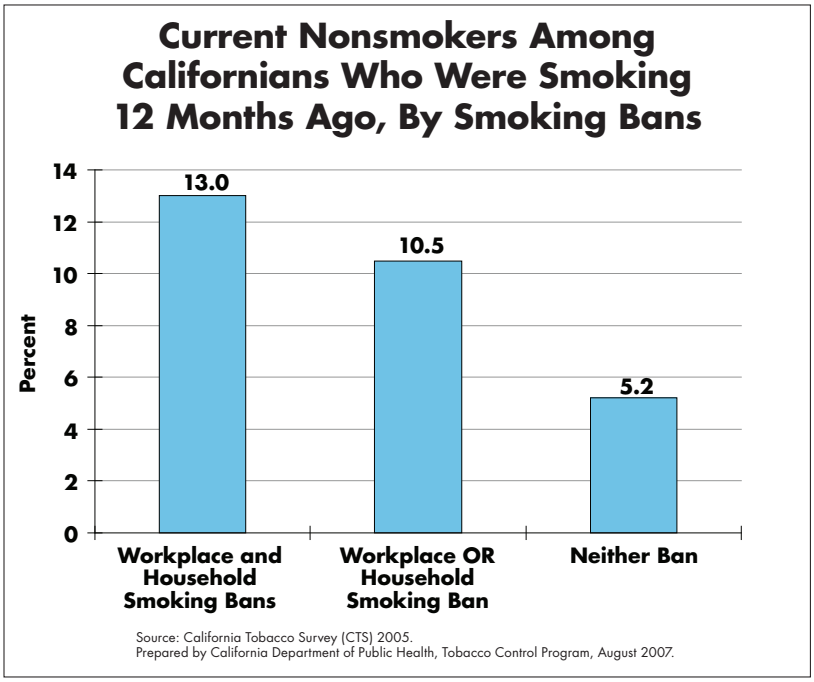
Smoking bans, whether in public or private places, improve quitting success by making it more difficult to smoke and communicating that nonsmoking is the norm (Fichtenberg and Glantz, 2002; Messer et al., 2008). Mirroring statewide progress in eliminating indoor public smoking, the percentage of Californians that have implemented a similar policy in the home has tripled, from about 20 percent of households in 1992-93 to about 60 percent in 2006-07. All ethnic groups have increased the prevalence of household smoking bans, with Hispanic and Asian households consistently the most likely to put one in place.

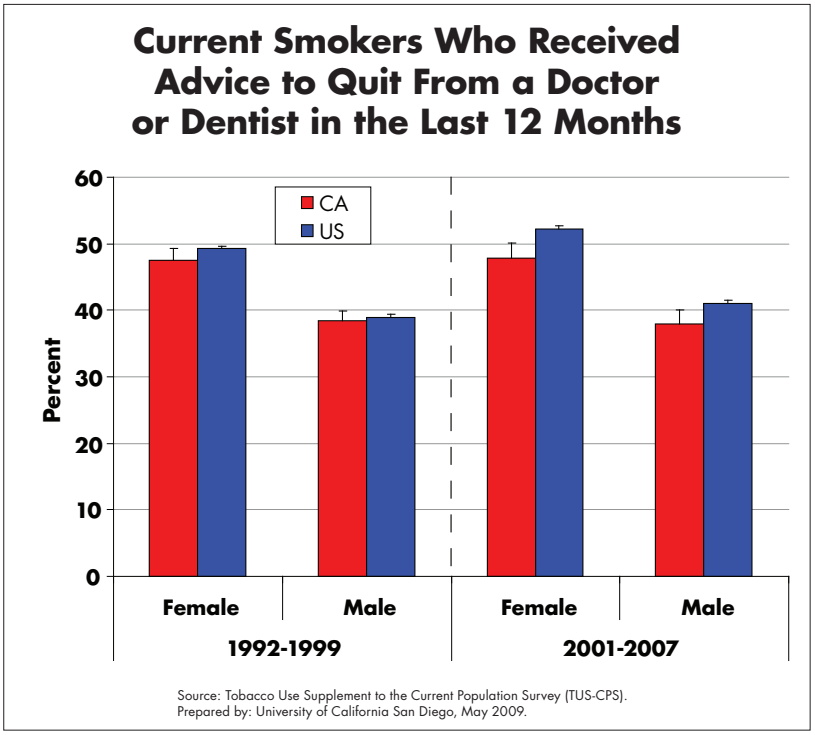


Source: Tobacco Use Supplement to the Current Population Survey (TUS-CPS).
Prepared by: University of California San Diego, May 2009.

Encouraging public and private smoking bans for all groups should help promote cessation, as people who were smoking a year ago are twice as likely to be a nonsmoker today if they have a smoking ban at home or at work (ten percent versus five percent). Those with a smoking ban both at home and at work are even more likely to be a nonsmoker today (13 percent).

Health care providers play an important role in promoting cessation. When doctors provide brief, simple advice about quitting smoking they increase the likelihood that patients will quit and remain quit a year later (Stead et al., 2008). Unfortunately, this is one area where California is lagging behind the rest of the United States. Between 2001 and 2007, California patients who smoke were no more likely to be advised to quit by a doctor or dentist than they were between 1992 and 1999 and were less likely to be advised to quit than their counterparts elsewhere in the United States. This suggests that provider advice is a significant area for improvement in efforts to promote cessation in California.





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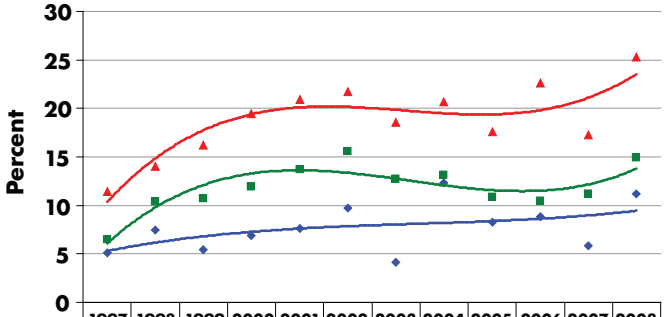
POPULATION-BASED CESSATION

Aided Versus Unaided Quit Attempts

For many in the field of tobacco control, the term "cessation" is short-hand for cessation treatment. Because the success rate for unaided quitting is so low and because various treatments exist that have been proven to increase the rate of success, the population benefits of unaided quitting are easily overlooked. Yet the great majority of smokers who quit successfully accomplish this on their own, without medications or counseling. More smokers would quit, and quit sooner, if they enjoyed barrier-free access to the full range of effective treatments (Curry et al., 1998), and if they used one or more of them with every quit attempt. But the resources required to increase access and use are unavailable to CTCP, both now and in the foreseeable future. By partnering with the private sector, especially health care, CTCP can leverage additional resources for treatment. Pursuant to the federal Patient Protection and Affordable Care Act of 2010, new health plans must cover preventive health care without co-payment beginning September 23, 2010 and this benefit will be required of all plans by 2018.

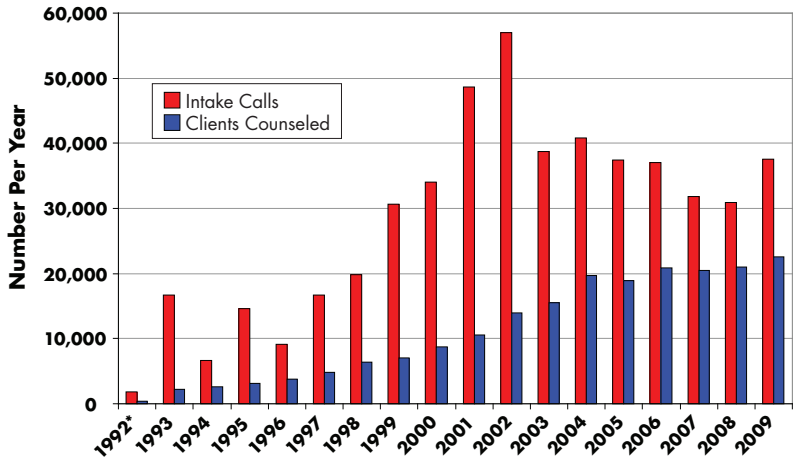
Use of Cessation Assistance by California Smokers Trying to Quit



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
◆ Counseling Advice	5.1	7.5	5.4	6.9	7.6	9.7	4.1	12.3	8.3	8.8	5.8	11.2
■ Self-Help Materials	6.5	10.4	10.7	11.9	13.7	15.6	12.7	13.1	10.9	10.5	11.2	14.9
▲ Medication	11.4	14	16.2	19.5	20.9	21.7	18.6	20.7	17.6	22.6	17.3	25.3

Source: California Adult Tobacco Survey (CATS). The data are weighted to the 2000 California population.
Prepared by: California Department of Public Health, Tobacco Control Program, May 2009.

Use of California Smokers' Helpline (Intake Calls & Clients Counseled) 1992–2009



* Numbers for 1992 are for the period 8/1/92-12/31/92.
Source: California Smokers' Helpline.
Prepared by: University of California San Diego, May 2009. Updated June 2010.

Survey data show that while use of treatment has gradually increased over time, it still is the exception rather than the rule.

For tobacco users as a group, "cold turkey" quitting is the norm. Survey data show that while use of treatment has gradually increased over time, it still is the exception rather than the rule. Despite years of advertising by the makers of pharmaceutical quitting aids, less than a quarter of smokers who tried to quit in the previous year had used them, and less than a tenth had used counseling support. Data from the California Smokers' Helpline (the Helpline) show that use of telephone support, in particular proactive counseling, has also increased over time; even so, the Helpline serves only about 1 percent of the state's smokers per year, whereas 70 percent of smokers say they want to quit.

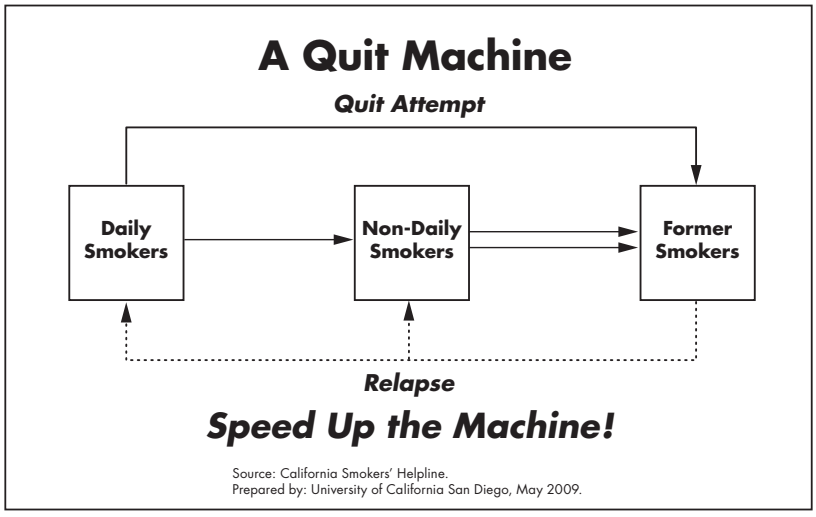
> CTCP can make quicker gains in population cessation by focusing more on the quantity than on the quality of quit attempts.

Resources and quitter preferences aside, CTCP can make quicker gains in population cessation by focusing more on the quantity than on the quality of quit attempts (Zhu, 2006). The rate at which a population successfully quits smoking is a function of two variables: the rate at which they try to quit (quantity), multiplied by the rate of efficacy for those attempts (quality). While in theory an increase in either term would increase the overall cessation rate, in practice the first is more amenable to change because quit attempts are widespread, whereas treatment use (which would increase the efficacy of those quit attempts) is not. In order to match the effect of a ten percent increase in the quit attempt rate, CTCP would have to boost the efficacy rate for all current quit attempts by ten percent, which is difficult because additional resources for treatment are not readily available and quitters themselves determine whether to use the available treatments. On the population level, quit attempts explain most of the differences in sub-group cessation rates, not treatment use.

> The focus should be on encouraging quit attempts and normalizing relapse.

A "Quit Machine"

Moreover, increasing the use of treatment may not lead to an increase in quit attempts, and given that it generally takes repeated quit attempts to succeed, an increase in quit attempts is more important. During the summit meeting, one speaker, Shu-Hong Zhu, presented an analysis of California data from multiple years showing that it takes an average of 14 attempts for individuals who do not use cessation aids to be successful in quitting. With cessation aids, the number is closer to 12 attempts. Therefore, the focus should be on encouraging quit attempts and normalizing relapse. Once smokers make a quit attempt they get on what Zhu called the "quit machine." In general, this takes them from daily smoking to non-daily smoking to non-smoking and in most cases back to smoking again. The goal should be to get smokers to step on to the quit machine and keep them cycling through the machine until they have successfully quit.



Population-based strategies that have the potential to motivate quit attempts include:

- increasing the price of tobacco products;
- imposing restrictions on when and where tobacco can be used;
- providing consistent health care provider advice to quit;
- reducing barriers to cessation aids;
- promoting quitting through media campaigns; and
- making smokers feel more hopeful about their chances of quitting successfully.

Anything that can speed up the machine, motivating relapsed smokers to make fresh quit attempts, will result in increased cessation rates. Conversely, anything that could slow the machine down should be avoided. An example of the latter is promoting quitting aids in such a way as to suggest that unless smokers use them, they will be unsuccessful at quitting. For smokers who do not have easy access to those aids or who are simply ambivalent about using them, such messages may provide an excuse for not even attempting to quit.

At the cessation summit, discussion among participants about the competing claims of quantity and quality in tobacco cessation was vigorous. But consensus emerged around the following guidelines for CTCP's efforts to increase cessation:

- strive to boost the quit attempt rate across the tobacco-using population;
- increase the desirability of quitting and the motivation of smokers to try quitting;
- normalize quitting, just as smoking has been denormalized;
- increase the sense of urgency about quitting earlier in life;
- be alert for differences among the quit attempt rates of disparate populations; and
- track the rate at which health care providers spur patients to try quitting.

HEALTH CARE SYSTEMS CHANGE

U.S. Public Health Service Guideline for Health Care Systems

The role of health care systems in tobacco cessation is to promote, provide coverage for, and support delivery of treatment, quit attempts, and successful quitting. According to the updated Treating Tobacco Use and Dependence: Clinical Practice Guideline, health care systems should institute the following institutional policies (Fiore et al., 2008):

- implement a tobacco user identification system in every clinic;
- provide adequate training, resources and feedback to ensure that providers consistently deliver effective treatments;
- dedicate staff to provide tobacco dependence treatment and assess the delivery of this treatment in staff performance evaluations;
- promote hospital policies that support and provide tobacco dependence services; and
- include effective tobacco dependence treatments as paid or covered services for all subscribers or members of health insurance packages.

An Illustrative Example Of Systems Change: Kaiser Permanente Northern California

One industry leader, Kaiser Permanente Northern California (KPNC), has identified tobacco cessation as a quality goal. KPNC measures performance and provides physician feedback, fostering healthy competition and offering incentives for good performance in this area. The organization has instituted a comprehensive systems approach that includes:

- smoke-free medical campuses;
- clinical practice guideline development;
- practice tools and staff training;
- benefits enhancements including Food and Drug Administration (FDA) approved pharmacotherapies; and
- behavioral support such as group classes, individual counseling, and an online program.

Beyond the systems changes, KPNC has institutionalized cessation even further with these additional approaches:

- expert consultation and collaboration with health agencies; and
- community benefits and legislation support.

The results of KPNC's investment in cessation have been remarkable. The adult smoking prevalence among its members decreased by a third in just a few years, from 12.2 percent in 2002 to 9.2 percent in 2005 (Schroeder, 2007). In 2007, 82.7 percent of patients were assessed for smoking and, if smokers, were advised to quit.

The adult smoking prevalence among its members decreased by a third in just a few years, from 12.2 percent in 2002 to 9.2 percent in 2005.

KPNC has received the highest rating reported by the California Cooperative Healthcare Reporting Initiative, a collaborative of health care purchasers, plans, and providers whose mission is to collect and report comparable, reliable performance data on all commercial plans in California.

In pursuing such an objective, KPNC enjoys the advantage of being a closed system, fully integrating insurance and patient care. Other health plans and

systems in California generally have control over just one or the other. But they can all implement at least some of the measures listed above. In fact it is vital that they do so, because these proactive measures accelerate quit attempts and reduce relapse. Plans and systems that reduce the smoking prevalence of their patient population not only improve their health outcomes, but also reduce their costs (Fellows et al., 2004). Helping health plans implement these measures should be a major focus of tobacco control efforts statewide.

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Recommended Strategies to Engage Health Care Systems

Strategy 1: Influence health plans to improve their coverage of tobacco dependence treatments recommended by the Clinical Practice Guideline.

- Develop an evidence-based model tobacco cessation benefit based on the Clinical Practice Guideline (Fiore et al., 2008), a business case for the return on investment (ROI), and guidance concerning the cessation-related requirements of health care reform legislation.
- Use the model benefit, business case, and guidance on health care reform to spur statewide plans, especially those overseen by Medi-Cal, to improve their coverage of effective treatments.
- Disseminate the model benefit, business case, and guidance to employers, insurance purchasers, and benefit managers to increase demand for improved coverage.
- Disseminate the model benefit, business case, and guidance to local health departments to use in their advocacy work with employers and local health plans.
- Maintain a database of treatments covered by California health plans, barriers to access (e.g., co-pays and yearly limits), and efforts to promote use.
- Publicize coverage on government Web sites and acknowledge plans that add benefits, remove barriers to access, or promote use.

Strategy 2: Help hospitals, clinics, mental health facilities, and substance abuse treatment centers to adopt smoke-free campus policies.

- Modify existing national toolkits for use with California hospitals and clinics.
- Develop particular guidelines for mental health and substance abuse treatment facilities.
- Distribute toolkits to health care facility administrators and provide training and technical assistance to help them implement smoke-free policies.
- Disseminate toolkits to local health departments for use in their smoke-free policy work.
- Maintain a database of systems and facilities that have adopted smoke-free campus policies.
- Publicly acknowledge locations that implement such policies (e.g., by garnering positive press coverage).

Strategy 3: Influence health care systems to adopt systematic approaches to cessation.

- Develop guidance for the systematic implementation of the Clinical Practice Guideline as a standard of care that includes: assessing tobacco use at every clinical visit, advising users to quit, discussing and prescribing quitting aids, referring to the Helpline or other behavioral support, and following up with patients post-treatment.
- Develop a case for adopting the standard of care with respect to improved quality and adherence to Joint Commission, Agency for Healthcare Research and Quality (AHRQ), and Healthcare Effectiveness Data and Information Set (HEDIS) measures.

- Develop a business case for the standard, emphasizing ROI.
- Disseminate the standard, rationale, and business case to health system administrators, medical directors, and quality improvement coordinators, and recruit physician champions to urge adoption of the standards.
- Provide training and technical assistance to help system administrators understand the standard of care and develop effective implementation plans.
- Monitor the findings of patient and provider surveys, such as the Consumer Assessment of Healthcare Providers and Systems and those administered by the National Committee for Quality Assurance and the Physician Consortium for Performance Improvement, to track progress in implementing systemic approaches to cessation and identify areas requiring increased attention.
- Publicly acknowledge systems that implement the standard of care (e.g., with an annual press release prior to open enrollment).

Strategy 4: Ensure that tobacco cessation is well supported by electronic medical records (EMR) and health registries.

- Develop a model for inclusion of tobacco cessation in EMR systems and registries, addressing: assessment of tobacco use as a vital sign, advice to quit, decision support for pharmacological quitting aids and guidance on drug interactions, referral to behavioral support services such as the Helpline, post-treatment follow up, and practice-level performance and prevalence tracking.
- Distribute the model to companies developing EMR programs for sale and urge them to incorporate it as a standard product feature, because it is easily done and in demand.
- Distribute the model to medical directors of hospital and clinic systems and recruit physician champions to urge its adoption because it will lighten physicians' workload while improving quality and HEDIS scores.
- Target in particular the recipients of the American Reinvestment and Recovery Act (ARRA) grants supporting conversion to EMR.
- Publicly acknowledge health systems that adopt the model and companies that incorporate it into EMR programs developed for sale.

Strategy 5: Target community health centers serving vulnerable populations.

- Advocate for a change in federally qualified health center requirements to include cessation services.
- Target clinic advisory committees, facility volunteers and providers to obtain their buy-in to strengthen cessation treatment and tracking measures.
- Train county health and human services home visitation workers that are associated with community health centers to implement the Ask-Advise-Refer intervention. In this three-minute or less intervention, health and human services workers are taught to routinely ask all clients about tobacco use, advise every client who uses tobacco in any form to quit, and then to refer tobacco users to quitlines or face-to-face cessation services.

ENGAGING HEALTH CARE PROVIDERS

U.S. Public Health Service Guidelines for Clinicians

Since 2000, the *Treating Tobacco Use and Dependence Clinical Practice Guideline* has recommended that health care providers implement the "5 A's" intervention:

1. *Ask*—Systematically identify all tobacco users at every patient visit.
2. *Advise*—Strongly urge all tobacco users to quit.
3. *Assess*—Determine patients' willingness to make a quit attempt.
4. *Assist*—Aid patients in quitting (i.e., provide counseling and medication)
5. *Arrange*—Ensure follow-up contact.

Providers (or clinicians) have not broadly implemented the 5 A's due to a pervasive belief that it takes too much time to do them correctly. Many clinician groups now promote a streamlined version of the intervention, such as "Ask-Advise-Refer" (Schroeder, 2005). The goal of the alternate approaches is to increase the likelihood of clinicians intervening by simplifying their task: they *Ask* and *Advise*, then hand the patient off to a quitline or other cessation service provider to *Assess*, *Assist*, and *Arrange*. Such efforts have been successful both in changing health care provider behavior and in generating referrals for cessation treatment providers.

An Illustrative Example of Health Care Provider Training: Rx for Change

A more basic reason for providers' failure to intervene on tobacco use is a lack of training. Fewer than five percent of health care provider schools provide training on tobacco cessation. One effort to address this need is Rx for Change.

Fewer than five percent of health care provider schools provide training on tobacco cessation.

Originally designed as a state-of-the-art training program for use in pharmacy schools, Rx for Change has since been expanded for use in other schools and as continuing medical education for a range of health professions (Corelli et al., 2005). It is intended as a turn key program, and all materials, including instructor tools, are available online. Rx for Change has been adapted for:

- Cancer care providers
- Surgical care providers
- Cardiologists
- Psychiatrists
- Mental health peer counselors
- Other peer counselors

Recommended Strategies to Engage Health Care Providers

Strategy 6: Influence medical, nursing, dental, pharmacy, and other professional schools to add training on tobacco cessation to their curricula.

- Identify tobacco control advocates among the leadership of health care professional associations and seek their advice on how best to ensure that students in their field receive effective education in tobacco cessation.
- Conduct an environmental scan of school curricula, assessing the extent to which students of various schools are trained to intervene effectively with their patients who use tobacco. For schools that do not provide training in cessation, determine whether another similar school has implemented an effective curriculum.

- Adapt Rx for Change, or the curricula of comparison schools, as needed.
- Work with advocates in the profession and school officials to encourage adoption of the curriculum.

Strategy 7: Provide continuing education in tobacco cessation to practicing health care providers.

- Adapt existing curricula for use by other health professions. At a minimum as a result of training, all participants should be able to:
  - increase patients' desire to quit and belief in their ability to do so;
  - encourage quit attempts;
  - normalize relapse;
  - incorporate cessation messages into chronic disease care models;
  - explain the pharmacotherapy treatments for tobacco dependence;
  - systematically implement the Ask-Advise-Refer intervention; and
  - understand the potential liability for not treating tobacco dependence;
- Develop self-directed, online courses based on these curricula and obtain continuing medical education (CME) credits for them.
- Aggressively promote CME courses through direct marketing, partnership activities with professional associations, advertising in their journals and Web sites, and presentations at professional conferences.

Strategy 8: Incorporate tobacco cessation as a standard of care in performance based and quality improvement measures.

- In coordination with professional associations, develop standards of care appropriate to the scope of practice for each profession (as in Strategy 3).
- Develop the case for providers to follow the standards of care for their profession, because intervening on tobacco use increases quit attempts, improves patient satisfaction, and helps their organization meet standards set by the Joint Commission, AHRQ, and HEDIS.
- Disseminate the case and standards of care to health plans and systems, encouraging them to implement the standard, reward good performance and improvement, and provide public recognition.
- Urge health care plans to offer incentives to top performing medical groups.

ENGAGING OTHER SYSTEMS TO PROMOTE CESSATION

Rationale for Engaging Behavioral Health Systems, Social Service Organizations, Employers, and Other Systems

We have already discussed the potential to extend the reach of CTCP by partnering with health care systems. Other systems may present similar opportunities, inasmuch as they serve, employ, or represent large numbers of tobacco users. Mental health treatment facilities, for example, serve consumers with very high prevalence of tobacco use. Mental health consumers are much likelier to smoke than persons with no mental illness (Lasser et al., 2000). Social service organizations likewise see large numbers of smokers, because they focus primarily on low-SES populations, and smoking prevalence is negatively correlated with household income. Employers also may see large numbers of tobacco users, especially those that employ either blue collar or low wage workers, both of which have high rates of smoking. Wherever large numbers of smokers come and go, there is an opportunity to promote cessation.

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For the prevalence of tobacco use to continue dropping in California, the strategy of social norm change must follow tobacco users into the systems where they work and receive services.

These systems are important for another reason: they each have a culture that can work either for or against tobacco use. For example, a 12-step program in which many of the sponsors smoke is implicitly promoting tobacco as a "safer" alternative to drugs or alcohol, even though tobacco kills more people than any other substance. A social service program that takes no position on tobacco, but whose staff can be seen smoking in front of the building, is supporting a norm of continued smoking. A company that denies cessation benefits to its employees and offers them no incentive to quit is also supporting smoking. For the prevalence of tobacco use to continue dropping in California, the strategy of social norm change must follow tobacco users into the systems where they work and receive services.

Many of the activities described below could be applied in other settings as well, such as schools and colleges, correctional facilities, military bases, and fire departments. Any institution with access to tobacco users and a desire to improve the lives of its clients and constituents can help to promote a norm of tobacco cessation.

Recommended Strategies to Engage Other Systems

Strategy 9: Promote tobacco cessation as a norm in mental health and substance use disorder systems.

- Designate tobacco users who have mental illness or substance use disorders as a CTCP priority population.
- Gather baseline data from a range of mental health and substance use disorder systems and providers on current beliefs, practices, and systems in place regarding cessation treatment.
- Educate policy makers on the special cessation needs and opportunities among persons with mental illness and substance use disorders.

- Coordinate with government agencies and nongovernmental organizations that set policy, articulate standards, and influence the culture and practice of treatment providers with respect to tobacco use and cessation to encourage recognition of tobacco cessation as an essential part of recovery.
- Develop and disseminate educational resources such as a fact sheet dispelling myths about tobacco use and cessation for persons with behavioral health issues.
- Develop trainings for mental health and substance abuse administrators to encourage systems-level change, trainings for providers to dispel myths surrounding tobacco use and encourage treatment for tobacco dependence, and trainings for peer counselors to increase their skills and knowledge in supporting quit attempts.
- Present at behavioral health conferences on the importance of implementing tobacco-free campuses and providing cessation treatment.
- Ensure that CTCP local lead agencies (LLAs) coordinate with the mental health and substance use organizations in their county, and that these organizations participate in their tobacco control coalitions.
- Advocate for tobacco cessation training to be a requirement for drug and alcohol counseling certification.
- Promote tobacco cessation on blogs, message boards and chat rooms that are read by behavioral health consumers.

Strategy 10: Encourage other social service organizations to adopt the goal of increasing tobacco cessation.

- Select social service organizations that serve large numbers of low-SES tobacco users and conduct key informant interviews to learn about the services they provide, identify entry points, and determine how they could be motivated to adopt a goal of increasing cessation.
- Coordinate with selected organizations to incorporate tobacco cessation in their messages and programs, emphasizing to their staff that they serve a low-SES population, that their effort to encourage cessation represents a small investment with a big return in their clients' lives, and that cessation should be integrated into their overall wellness message.
- Obtain a directive from the leadership of social service agencies establishing smoke free campuses and providing cessation benefits for their employees.

Strategy 11: Encourage employers and labor groups to promote tobacco cessation among their employees and members.

- Develop and disseminate to employers a business case for the ROI of providing comprehensive cessation coverage and guidance on the cessation-related requirements of health care reform legislation.
- Advocate for the inclusion of smoking cessation benefits based on the Clinical Practice Guidelines in standard health insurance benefit packages and the integration of cessation coverage with existing wellness programs.
- Advise employers to adopt a smoke-free campus policy and to promote quitting in their signage and other communications.
- Encourage employers to credit nonsmoking employees with a monetary amount toward their annual health insurance premium, to provide discounted life insurance premiums for nonsmokers, and to provide incentives for smoking beneficiaries who quit.
- Encourage businesses to contract with the Helpline or other quitline provider for cost sharing of tobacco cessation services.

USING MEDIA AND PUBLIC RELATIONS TO PROMOTE CESSATION

Media is a key population-based strategy for decreasing tobacco use (National Cancer Institute, 2008; Wakefield et al., 2008). Because it is expensive, media use must be as strategic as possible. Studies have shown that high negative emotion messages perform better than funny or emotionally neutral ads, as viewers are more likely to remember, think about and discuss them. Studies also have shown that ads that perform well tend to do so among many population subgroups. This means there is little need to make specific ads tailored to smaller population subgroups, but it is important to ensure reach of the ad to subgroups. Smokers "know" smoking causes serious disease, but often they do not feel it will affect them. They may not appreciate the magnitude of the risk or what it is like to have a fatal smoking-related condition. Media campaigns can make this more concrete, increase the urgency for quitting, and remind and reinforce the need to quit. Narrative messages (those that tell a story and are more personal) and graphic messages (which command attention with engaging visual or auditory information) can be understood by many.

There is little need to make specific ads tailored to smaller population subgroups, but it is important to ensure reach of the ad to subgroups.

Recommended Strategies to Promote Cessation Through Media and Public Relations

Strategy 12: Use mass media to promote quit attempts.

- Select culturally appropriate media messages based primarily on their ability to motivate quit attempts—whether aided or unaided—and only secondarily on their ability to motivate treatment use (e.g., calls to the Helpline).
- Research whether graphic messages and scare tactics or messages instilling hope and self confidence are more effective in motivating quit attempts.
- Gear ads toward low-SES smokers and air them during programs that have high interest among this population.
- Use demographic consumer information to target areas with the greatest concentrations of smokers.

Strategy 13: Use media and public relations to normalize social support for cessation.

- To normalize health care provider assistance, depict them in culturally appropriate ads, helping their patients quit smoking.
- Research whether ads that depict friends and family helping their loved ones quit smoking motivates similar behavior in nonsmoking viewers and if so develop a culturally appropriate campaign around this theme.
- Conduct a "Quit and Win" contest for nonsmokers, in which they compete for a prize by helping smokers quit.
- Disseminate the Helpline's data on proxy callers, to show that taking action to help a loved one quit is normal, especially among Asians and Latinos.
- Identify personal stories of smokers who have quit with the help of a friend or family member that can be used in earned media opportunities such as news stories, talk shows, editorials, and letters.

Strategy 14: Use social media and mobile technologies to promote quit attempts by young adults.

- Develop a presence on social networking sites such as Facebook and MySpace to promote cessation and the Helpline.
- Hold a YouTube contest to create the best short video promoting cessation.
- Use the winning video or other resources in a viral marketing campaign to spread the word about quitting smoking.
- Develop a text messaging support service geared toward young adults and incorporate it into regular Helpline service.
- Partner with colleges to promote cessation in their health clinics.

Strategy 15: Use place-based campaigns to reach concentrated, low-SES populations.

- Create local cessation campaigns using low and no cost vehicles such as pay stubs, posters, and smoke-free signage.
- Incorporate cessation messages and the Helpline number into LLAs' press releases and other communications.
- Encourage outdoor workplaces to adopt smoke-free policies and acknowledge those that do with positive public relations, incorporating cessation messages while encouraging the community to support them.
- Target small business coalitions to adopt smoke-free messages such as providing gold star accreditation to businesses with smoke-free campuses and cessation programs.
- Expand tobacco control coalitions to include business, labor, behavioral health providers, faith based programs, barber and beauty shops, etc., and call upon coalition members to incorporate cessation messaging into their newsletters, emails, and other communications.
- Encourage groups of trusted professionals in the community, ranging from barbers and beauticians to public health nurses and home visitation workers, to implement the Ask-Advise-Refer intervention.

IMPLEMENTATION OF THE QUIT PLAN

Summary of Recommended Strategies

1. Influence health plans to improve their coverage of tobacco dependence treatments recommended by the Clinical Practice Guideline.
2. Help hospitals, clinics, mental health facilities, and substance abuse treatment centers to adopt smoke-free campus policies.
3. Influence health care systems to adopt systematic approaches to cessation.
4. Ensure that tobacco cessation is well supported by EMR and health registries.
5. Target community health centers serving vulnerable populations.
6. Influence medical, nursing, dental, pharmacy, and other professional schools to add training on tobacco cessation to their curricula.
7. Provide continuing education in tobacco cessation to practicing health care providers.
8. Incorporate tobacco cessation as a standard of care in performance based and quality improvement measures.
9. Promote tobacco cessation as a norm in mental health and substance use disorder systems.
10. Encourage other social service organizations to adopt the goal of increasing tobacco cessation.
11. Encourage employers and labor groups to promote tobacco cessation among their employees and members.
12. Use mass media to promote quit attempts.
13. Use media and public relations to normalize social support for cessation.
14. Use social media and mobile technologies to promote quit attempts by young adults.
15. Use place based campaigns to reach concentrated, low-SES populations.

Organizations Playing Lead Roles in the Quit Plan

CTCP

Strategic Planning and Policy Unit

- Guide ongoing development and revision of the Quit Plan.
- Facilitate connections with other state government programs and departments.

Media Unit

- Develop statewide media and public relations campaigns (Strategies 12-14).

Local Programs Unit

- Translate the Quit Plan into intervention activities and contract deliverables.
- Oversee contractors' progress in implementing the Quit Plan.

Surveillance and Evaluation Unit

- Monitor statewide tobacco prevalence and cessation activity.
- Evaluate overall effectiveness of the Quit Plan.

CTCP-funded organizations

Center for Tobacco Cessation

- Support CTCP in developing and revising the Quit Plan.
- Provide training and technical assistance, as needed, to all organizations implementing the Quit Plan.
- Provide CME (Strategy 7).

California Smokers' Helpline

- Serve as the state's primary tobacco cessation treatment provider.
- Promote and accept referrals.

LLAs

- Operationalize the Quit Plan on the local level.
- Through advocacy and collaboration, serve as the primary drivers of progress on the Quit Plan by non-CTCP-funded organizations such as hospitals,

behavioral health facilities, social service organizations, and employers (Strategies 1-6, 8 11, 15).

California Youth Advocacy Network

- In coordination with the CTCP Media Unit, develop and implement a campaign targeting young adults (Strategy 14).

Other CDPH, Division of Chronic Disease and Injury Control programs (California Diabetes Program, California Heart Disease and Stroke Prevention Program, California Asthma Public Health Initiative)

- Help to engage health care systems and providers in the activities of the Quit Plan (Strategies 1-8).

California Department of Health Care Services, Medi-Cal

- Support health care systems change in Medi-Cal Fee-for-Service and Managed Care (Strategies 1-5).

California Department of Mental Health and California Department of Alcohol and Drug Programs

- Support smoke-free mental health and substance abuse treatment facilities (Strategy 2) and norm change across the field of behavioral health (Strategy 9).

California Department of Social Services

- Support education and outreach to licensed facilities and providers to engage them in promoting available cessation services, such as the Helpline.

California Hospital Association

- Support health care systems change to member hospitals (Strategies 2-4).

California Association of Health Plans and Chambers of Commerce

- Support comprehensive cessation benefits to member plans (Strategy 1).

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SUMMIT PARTICIPANTS

Christopher Anderson, Program Director, California Smokers' Helpline and Center for Tobacco Cessation, University of California, San Diego

Linda Aragon, Director, Los Angeles County Department of Public Health, Tobacco Control and Prevention Program

Majel Arnold, California Tobacco Control Program, California Department of Public Health

Xylina Bean, Founder and CEO, SHIELDS for Families

Annie Beigel, Field Director, Project ASSIST, New York State Tobacco Control Program

Michael Burke, Program Coordinator, Mayo Clinic Nicotine Dependence Center

Robin Corelli, Licensed Pharmacist and Professor of Clinical Pharmacy, University of California, San Francisco School of Pharmacy

David Cowling, Chief, Evaluation Unit, California Tobacco Control Program, California Department of Public Health

Bridget Gleason, Senior Manager, Value-Based Purchasing, Pacific Business Group on Health

Ali Goldstein, Project Manager, Kaiser Permanente Northern California

Tonia Hagaman, Chief, Local Programs and Advocacy Campaigns Unit, California Tobacco Control Program, California Department of Public Health

Kirsten Hansen, Curriculum Development Manager, Center for Tobacco Cessation, University of California, San Diego

Karen Hudmon, Associate Professor, Purdue University School of Pharmacy

Corinne Husten, Interim President, Partnership for Prevention

Matthew Keelin, Director of Health Initiatives, National Jewish Health Call Center

Byron Kennedy, Preventive Medicine Resident, California Tobacco Control Program, California Department of Public Health

Paul Knepprath, Vice President of Advocacy and Health Initiatives, American Lung Association

Beth Lillard, Project Director, Bay Area Community Resources

Cindy Baez Lopes, President, BlueMarble Communications

Tami Macaller, Senior Health Promotion Specialist, California Diabetes Program

Nancy Mahannah, Health Promotion Division Manager, Mono County Tobacco Education Program

Timothy McAfee, Chief Medical Officer, Free and Clear

Amanda McCartney, Media Specialist, California Tobacco Control Program, California Department of Public Health

Ed Mendoza, Deputy Director, Office of the Patient Advocate

Jamie Morgan, Senior Legislative Director, American Heart Association

Chad Morris, Associate Professor, University of Colorado, Denver, Department of Psychiatry

Michael Ong, Assistant Professor, University of California, Los Angeles

John Pierce, Behavioral Epidemiologist, University of California, San Diego

Jolie Bain Pillsbury, President and Founder, Sherbrooke Consulting

Michael Renner, Executive Director, former Ohio Tobacco Prevention Foundation.

Connie Revell, Deputy Director, Smoking Cessation Leadership Center, University of California, San Francisco

Reason Reyes, Technical Assistance Manager, Smoking Cessation Leadership Center, University of California, San Francisco

Austin Risbeck, Dental Hygienist, Veterans Affairs Medical Center, San Francisco

April Roeseler, Chief, Local Programs and Information Services, California Tobacco Control Program, California Department of Public Health

Patrick Romano, Professor of Medicine and Pediatrics, Division of General Medicine and Center for Healthcare Policy and Research, University of California, Davis

Alecia Sierra Sanchez, Legislative Advocate, American Cancer Society, California Division

Linda Sarna, Professor, University of California, Los Angeles School of Nursing

Catherine Saucedo, Director of Strategic Marketing, Smoking Cessation Leadership Center, University of California, San Francisco

Steven Schroeder, Professor of Health and Health Care, Division of General Internal Medicine, Department of Medicine, University of California, San Francisco, and Director, Smoking Cessation Leadership Center

Scott Sherman, Interim Chief, Section of Geriatrics, New York University School of Medicine, Veterans Affairs New York Harbor Healthcare System

Jennifer Singleterry, Manager of Cessation Policy, American Lung Association

Kenneth Slenkovich, Program Director and Director of Cessation Services, former Ohio Tobacco Prevention Foundation

Colleen Stevens, Chief, Media Unit, California Tobacco Control Program, California Department of Public Health

Beth Thompson, Project Director, Shasta County Public Health Department, Tobacco Education Program

Elisa Tong, Assistant Professor of Medicine, University of California, Davis

Melanie Wakefield, Director, Centre for Behavioral Research in Cancer at The Cancer Council Victoria in Melbourne, Australia

Donna Warner, Director of Cessation Policy and Program Development, Massachusetts Tobacco Control Program

Seleda Williams, Public Health Medical Officer, Office of Clinical Preventive Services, California Department of Health Care Services

Shu-Hong Zhu, Professor of Family and Preventive Medicine and Principal Investigator of the California Smokers' Helpline and Center for Tobacco Cessation, School of Medicine, University of California, San Diego